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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEFS

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic:

Understanding Health Experiences and Values in Order to Address Social Determinants of Health

Why This Is an Important Topic to Address (brief description):

Health experiences and values influence personal health choices, utilization of services, treatment decisions and ultimately outcomes. Understanding these experiences and values across a diverse population requires multiple participatory approaches that reveal nuanced information across individuals' physical, economic, and social contexts. Having this understanding is necessary for designing effective interventions that can achieve health equity.

What We Think We Know (Bulleted evidence + Seminal references):

- People perceive health holistically and their views are influenced by the multiple contexts in which they operate. In contrast, the provision of health services is often reductionist, focused on specific disease states and/or care processes
- Patient health experiences and engagement are positively associated with health outcomes[1,2,3]
- Patients and clinicians often prioritize desired health outcomes differently[4] and have different incentives for doing so[5]
- Multiple participatory approaches are required to understand the broad range of health experiences, engage diverse voices, and involve patients and the public in health improvement[6-9]

[1]Frampton SB et al. (2016) Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care. Discussion Paper. National Academy of Medicine.

[2]Coulter, A. (2012). Patient engagement—what works? *The Journal of ambulatory care management*, *35*(2), 80-89.

[3]Doyle, C et al. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ open*, *3*(1), e001570.

[4]Mühlbacher, A. C. et al. (2013). Patient preferences versus physicians' judgement: does it make a difference in healthcare decision making? *Applied health economics and health policy*, *11*(3), 163-180.

[5]Martin, C. et al. (2009). Complex adaptive chronic care. *Journal of evaluation in clinical practice*, *15*(3), 571-577.

[6]Burns, K. K. et al. (2014). 'Practical' resources to support patient and family engagement in healthcare decisions: a scoping review. *BMC Health Services* Research, 14, 175.

[7]Herxheimer, A. et al. (2004). The DIPEx project: collecting personal experiences of illness and health care. *Narrative research in health and illness*, 115-131.

[8]Arcia A. et al. Sometimes More is More: Iterative Participatory Design of Infographics for Engagement of Community Members with Varying Levels of Health Literacy. J Am Med Inform Assoc. 2015;23(1):174–83

[9]Beresford, P. (2013). Beyond the usual suspects: towards inclusive user involvement. Shaping our Lives. http://www.invo.org.uk/beyond-the-usual-suspects-towards-inclusive-user-involvement

Questions to Address in Group Discussion:

1) What would be needed to robustly incorporate health experiences and values into research, education and practice interventions (e.g. structures, resources, policies, incentives)?
2) What particular methods excite you and seem feasible in order to elicit health experiences and values?
3) What kinds of barriers might we encounter with regard to incorporating health experiences and values and what strategies might overcome these barriers?

Implications for Action:

- Fund research that examines the role of understanding health experiences and values in addressing social determinants of health (SDOH)
- Promote health sciences and CME curriculum development and implementation that integrates health experiences and values
- Develop shared statements from health policy organizations about the crucial role of health experiences and patients' values in achieving health equity
- Encourage health sector engagement of patients and use of health experiences data to inform SDOH interventions
- Promote practice standards and implement tools and workflows which ensure that health experiences and values are able to inform whole person healthcare

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Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic:

Identifying and addressing patients' social and economic needs in the context of clinical care

Why This Is an Important Topic to Address (brief description):

Substantial evidence documents the social patterning of disease. At the same time, there is national concern about the expense and deficiencies of traditional health care services. Together these forces are fueling interest in addressing social determinants of health (SDH) within the health care delivery system. While recognizing that important work to improve social and economic conditions occurs outside of health care settings, many health care professional organizations also have recommended better identifying and addressing these hardships in primary care as one part of a more comprehensive strategy around SDH. A surge of experimentation around social and economic hardship screening and intervention has followed. However, research on these experiments has not kept pace. Limited evidence examines how these efforts impact individual and population health, decrease avoidable utilization, and/or improve revenue under value-based payment systems. Implementation science research will also be required to better facilitate adoption and dissemination of these innovations in diverse medical settings.

What We Think We Know (Bulleted evidence + Seminal references):

- Social determinants of health are associated with a wide range of health outcomes across the life course;
- The National Academy of Medicine, CMMI, NACHC, AAP and other health leaders and professional organizations have recommended validated social screening tools be used in clinical settings to identify social and economic hardships;
- Preliminary intervention research demonstrates that acting on SDH can impact health outcomes for children and adults, though some social conditions are more actionable than others in primary care clinical settings.

Key References

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--Alley DE, Asomugha CN, Conway PH, Sanghavi DM. Accountable health communities—addressing social needs through Medicare and Medicaid. N Engl J Med. 2016;374(1):8–11.
--American Academy of Pediatrics Council On Community. Poverty and child health in the United

States. Pediatrics. 2016;137(4).
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--Gottlieb LM, Hessler D, Long D, et al. Effects of social needs screening and in-person service navigation on child health: A randomized clinical trial. *JAMA Pediatr.* 2016:e162521.
--Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing unmet basic resource needs as part of chronic cardiometabolic disease management. *JAMA internal medicine.* 2017;177(2):244-252.
--Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics.* 2015;135(2):e296-304.

Questions for Group Discussion

Questions to Address in Group Discussion:

- What are the roles and responsibilities of primary care in identifying and addressing patients' social determinants of health?
- What are implementers and researchers already investing in around basic resource needs screening and intervention? How do we better coordinate that work? (e.g. could we map innovations/research related to SDH and clinical care delivery?)
- What are the steps we need to take to increase evidence-based practice around identifying and addressing patients' social and economic needs in the context of high quality primary care?
- Who are the different stakeholders for this integration work and what evidence is needed to "speak to" those stakeholders?
- How could our professional and payer organizations help catalyze more work at the intersection of medical and social care?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

Map the field
--Support mapping effort to better understand who is doing what in this rapidly expanding area, including in research, education, policy/payment, and practice innovation

Support rigorous research in this field
--Cull and disseminate existing effectiveness and implementation evidence
--Fund new high quality research, including screening tool validation and impacts of interventions on SDH, patient and provider experience of care, patient health and wellbeing, health care costs and utilization, and population health and equity.

Promote practice standards
--Promote use of validated tools and effective interventions where that evidence exists

Support health care policy changes that facilitate implementation and sustainability of evidence-based interventions
--Develop shared statements from health policy organizations on identifying and addressing social determinants in the context of care delivery
--Encourage health sector incentives that support social and medical care integration (performance metrics, value based care models that enable CHW/Navigators, incorporating SDH in electronic heath records, etc.)

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Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic: Communities Working Together to Improve Health and Reduce Disparities

Partnerships between health care, public health and communities are underway across the country, delivering striking results through shared data and coordinated efforts building on community strengths. Family medicine, and primary care more broadly, have the opportunity to work with this broad movement, reshaping our methods of providing care and our training programs so that we provide community-responsive care that improves outcomes and reduces disparities.

Why This Is an Important Topic to Address (brief description):

Most illness is now chronic, with roots in the community, and is not easily affected by office - or health system-based interventions. At the same time, data from electronic health records provides the ability to understand and see patterns of illness and risk within our communities, allowing much greater precision in identification of groups at risk. Add detailed information on community resources, and the opportunity arises for coordinated, partnered interventions designed by and with the community, that provides services in ways that are responsive to community needs and improves outcomes in ways the community values. There are now more than 400 such partnerships across the country, with the number expanding rapidly as evidence grows on the value and impact of these programs. Unfortunately, family medicine and primary care are often absent from these partnerships, reflecting our overly busy lives, as well as our long-standing focus on the office and hospital. The opportunity exists now to find, connect with, and participate in these partnerships, adding in our insights and perspectives, and gaining insights and perspectives on the needs, strengths, and resources of the community.

What We Think We Know (Bulleted evidence + Seminal references):

- Most Illness is chronic
- Chronic Illness has its roots in the community.
- Communities vary – across the country, within states, and within cities.
- Community partnerships to improve health are numerous and growing rapidly.
- Coordinated interventions can be highly effective – and cost effective.
- Family Medicine is sometimes an active participant in these partnerships– but not always.
- There is an opportunity to connect with programs in our own communities, learning the skills of partnership, and the techniques of community engagement and outcomes improvement
- This is a new skill set – and our learners are often the leaders within our systems.

References:

- Practical Playbook (PPB) website: www.practicalplaybook.com
- The Practical Playbook. Public Health and Primary Care together. Edited by J. Lloyd Michener, Denise

Koo, Brian C. Castrucci, and James B. Sprague, Oxford University Press 2016

- Vital Directions for Health and Health Care: Priorities from a National Academy of Medicine Initiative

Questions for Group Discussion

Questions to Address in Group Discussion:

Our model of change is based on incremental improvement and consensus-based change, with expertise passed from the experienced to the novice. But the movement to community-based health improvement has its roots outside medicine, broad bipartisan support, and is 'in play' in states and cities across the country. How do we effectively connect to this accelerating political and social movement?

What do we need to be teaching our students and residents about the role of communities in health, and how to use data and partnerships to improve health outcomes – inside and outside the office?

What do we need to be doing in our practices to role model the partnerships that are proving effective in improving health – even before payment models have aligned with them?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- What are the opportunities for states to realign funding streams to use data to target and support cost effective interventions?*
- What are the key 'packages' of reforms that states should consider if/when block grants become an important option?*
- What role can state chapters play in bringing policy ideas across state lines, so that successful programs can quickly scale?*

*Indicates that this idea is already under discussion across states

Important Unanswered Questions:

- What are the roles of primary care/family medicine in successful partnerships? It is NOT always leadership – is it advocacy, funding, linking with at-risk patients…?
- What are the methods of helping eager students and residents learn these skills, given curricula are already overburdened?
- How do we learn ourselves, since these programs are based in and one of the community?

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic

Community Health Improvement Plans & Patient-Centered Primary Care Homes as Tools to Address Health Disparities

Why This Is an Important Topic to Address (brief description):

Health disparities result in untold human and economic costs to Oregon and the entire nation. Addressing these disparities requires a multi-pronged approach, focused at the individual, family, community, and state levels. Oregon has begun to succeed in moving the needle on health disparities through the Community Health Improvement Plans developed by Coordinated Care Organizations, and by developing, implementing, and financially supporting a unique model for Patient-Centered Primary Care Homes.

What We Think We Know (Bulleted evidence + Seminal references):

- Investment in primary care facilitates achieving the triple aim by improving outcomes, delivering better care, and saving money
- Providing a wider range of services (e.g. behavioral health, group visits, or patient education options) in primary care settings increases the likelihood that those most affected by health disparities will have access to these services
- However, investment in primary care alone is insufficient, as many of the causes of health disparities occur in the community, not in the medical setting
- Community health improvement plans developed in conjunction with the affected communities can have a significant impact on overall health in those communities

Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings http://www.oregon.gov/oha/pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf

Oregon Patient-Centered Primary Care Home Program
http://www.oregon.gov/oha/pcpch/Pages/index.aspx
Oregon Health Policy Board Coordinated Care Organization Community Health Improvement Plans https://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/cco-chip.aspx

Culturally Grounded Prevention for Minority Youth Populations: A Systematic Review of the Literature. [Review] Lauricella M; Valdez JK; Okamoto SK; Helm S; Zaremba C. *Journal of Primary Prevention. 37(1):11-32, 2016 Feb.*

Questions for Group Discussion

Questions to Address in Group Discussion

- How can Community Health Improvement Plans (CHIPs) be used to address social determinants of health?
- What can states do to promote investment in primary care?
- What metrics and outcome measures for primary care investment and CHIPs truly assess reductions in health disparities?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action)

- Development of standardized metrics and outcome measures for use by both Medicaid and commercial insurers to measure achievement of patient-centered outcomes as a result of investment in primary care
- Measurement of improved outcomes of CHIPs that result from robust stakeholder participation
- State & Federal policy (statute and rule) that promote investment in primary care

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Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic

An Action Learning Approach to Teaching the Social Determinants of Health

Why This Is an Important Topic to Address (brief description):

- Inequities in health stem largely from social determinants, and result in significant differences in health and health outcomes. Addressing the underlying causes of disease and ill health is necessary to improve the health of individuals, communities and large populations. Health professionals (HP) need to be educated about these root causes of disease, how to address them and approach them together with communities, learning from the communities' expertise.
- Most approaches to educating HP about the "Social Determinants of Health" (SDH) have involved mostly classroom activities and lecturing, without emphasis on true community engagement or experiential learning in the community with community members as equal partners.
- Clinicians' training influences the way they will practice for the rest of their professional careers. Providing these learners with experiential opportunities to engage in community improvement and addressing SDH will hopefully affect their ability to engage communities and improve health throughout the rest of their lives.

What We Think We Know (Bulleted evidence + Seminal references):

- The literature shows us multiple frameworks for addressing the SDH that can be adapted to teaching.
- Some Frameworks put the community in charge of addressing the improvement of population health and the well-being of the community. In some cities, public health departments address upstream, structural and social factors that perpetuate health inequities. WHO provides a framework with a broad public health and systems context for impacting the SDH. CDC's Tom Frieden's framework shows us the largest impact for population health interventions to improve health is to address socioeconomic factors, yet we continue to educate clinicians to mostly only work on the top of the pyramid, with less impact in overall health.
- New frameworks and requirements for education of health professionals on the SDH are emerging for all health professions. ACGME now requires that institutions engage residents in the use of data and QI to improve systems of care, reduce health care disparities, and improve patient outcomes through experiential learning. The ABFM addresses SDH in its milestones.
- The recently published IOM Framework for Educating Health Professionals to Address the SDH exhorts us to create -through education- highly competent professionals who understand and act on the SDH in ways that advance communities and individuals toward greater health equity.

References

- A Framework for Educating Health Professionals to Address the Social Determinants of Health authored by the Committee on Educating Health Professionals to Address the SDH; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. The PDF is available from The National Academy Press at http://www.nap.edu/21923
- The Population Health Milestone-Based Curriculum with link to different specialty reports: https://cfm.duke.edu/population-health/population-health-milestones-graduate-medical-education Full report https://cfm.duke.edu/files/field/attachments/Population%20Health%20Milestones%20in%20Graduate%20Medical%20Education_web_0.pdf
- Innovations in Graduate Medical Education Aligning Residency Training with Changing Societal Needs. A Report on Six Regional Conferences from the Josiah Macy Jr. Foundation and several academic medical centers: http://macyfoundation.org/docs/macy_pubs/JMF_2016_Monograph_web.pdf
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- Rural community health and well-being: A guide to action. Annis R, Racher F, Beattie M Brandon, Manitoba: Rural Development Institute; 2004 https://www.researchgate.net/publication/242551842_Rural_Community_Health_and_Well-Being_A_Guide_to_Action
- A New Way to Talk about the Social Determinants of Health. Vulnerable Populations Portfolio, RWJF http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023
- The Practical Playbook: Helping Public Health and Primary Care Work Together to Improve Population Health. https://www.practicalplaybook.org/
- ACGME CLER brochure accessed 4.10.17 https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Brochure.pdf
- Bay Area Regional Health Inequities Initiative: BARHII's Public Health Framework for Reducing Health Inequities. 2014 http://barhii.org/framework/
- Structural competency, website calling for a new approach to the relationships among race, class, and symptom expression- multiple links to articles and curriculum: http://structuralcompetency.org
- Using Social Determinants of Health to Link Health Workforce Diversity, Care Quality and Access, and Health Disparities to Achieve Health Equity in Nursing. Williams SD, Hansen K, Smithey M, et al. Public Health Reports. 2014;129 (Suppl 2):32-36
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- CDC Materials pertinent to social determinants of health http://www.cdc.gov/socialdeterminants/Resources.html
- Principles of Community Engagement- 2nd edition (2011) https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
- Frieden TR. A framework for public health action. Am J Public Health. 2010;100(4):590–595.
- Wear, Delese PhD; Kuczewski, Mark G. PhD. Perspective: Medical Students Perceptions of the Poor: What Impact Can Medical Education Have? Academic Medicine: July 2008 Vol 83- Issue 7 pp 639-645
- Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century http://www.nap.edu/catalog.php?record_id=10542#toc
- Council on Graduate Medical Education Twentieth Report, Advancing Primary Care, 2010 http://www.cogme.gov/20thReport/cogme20threport.pdf
- Educating Nurses and Physicians: Toward New Horizons. Advancing Inter-Professional Education in Academic Health Centers, June 2010 http://www.macyfoundation.org/docs/macy_pubs/JMF_Carnegie_Summary_WebVersion_%283%29.pdf

Questions for Group Discussion

Questions to Address in Group Discussion

- What do we need to do to graduate true "upstreamists" in the delivery of health care? What kind of curriculum can we develop, and implement that will educate clinicians about SDH, engaging them with community partners in a collaborative manner? What should the elements of the curriculum be?
- How should academic centers create (and pay for) time in clinicians' schedules to allow them to become involved in experiences to address the SDH?
- How do we get out of traditional lectures and train people who will look for the root causes of illness, and help advance whole communities toward greater health equity?
- What methods should be used to evaluate the learner and community outcomes of the new curriculum on SDH? What kind of data should be gathered and what should be measured to track and assess skill development?
- How do we engage nay-sayers, those who think medical education should only involve the "biomedical determinants of health"?
- Will educating HP learners about SDH help improve the health and health equity of the nation? How will we measure success? Is there a way to measure return on investment?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action)

- New non-traditional lectures and models of training health professionals will emerge.
- Academic centers will need to provide more time for education of social determinants on health, give social determinants the importance currently given to training on the "biological determinants of health".
- Learners, faculty and researchers will dedicate more time to the understanding of the root causes of illness, they will engage with communities, and help advance whole communities toward greater health equity.
- The outcomes of these new education plans will need to be researched.
- There needs to be a common methodology developed for capturing the impact of curriculums that address the social determinants of health. Metrics to measure the success of these new educational models will need to be defined.
- Can/Will Electronic Health Records assess community data and link SDH to individual patient care?

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic:

Improving patient outcomes by enhancing student understanding of social determinants of health

Why This Is an Important Topic to Address (brief description):

Examination of the social determinants of health (SDH) provides a broad context for explaining health and deviations from health by factoring in the social and physical environments of individuals, groups, and communities in efforts to promote health and reduce health disparities. Taking a two-step process to address individual level social determinants and subsequently integrate SDH into curriculum design can 1) address student's individual level social determinants to minimize barriers to achieving educational goals and also enhances student's ability to identify SDH in the populations they serve. Further, this approach to understanding health disparities requires a new conceptualization of nursing education in general, in order to help students, identify and understand the impact of adverse physical and social environments and become empowered to bring about positive change to enhance their career development and leadership abilities in order to bring about health equity. It is critical to integrate the relationships among SDH, health access, health disparities, and health equity throughout curriculums along with related learning experiences to truly imbed this knowledge in the nursing student's critical thinking process.

What We Think We Know (Bulleted evidence + Seminal references):

- There is strong evidence of the importance of ensuring that all health professional students, including nursing students world-wide, have a thorough knowledge base, understanding of the evidence, and the cultural sensitivities and competencies to effectively address health inequities and SDH.
- The World Health Organization, in conjunction with the Commission on Health Disparities, has recommended that educational institutions and relevant ministries integrate SDH into standard and compulsory training of medical and health professions students.
- It is thus essential that nursing education give priority to ensuring high visibility to the relationships among health equity concepts, that attention to these concepts be woven throughout academic programs in theoretical, scientific, and experiential experiences, and that competency and commitment for addressing health disparities/inequalities be designated as a program outcome.

Questions for Group Discussion

Questions to Address in Group Discussion:

- What are the barriers to addressing the students individual level social determinants of health? (Preparedness and resources for addressing identified barriers)
- How to evaluate students' understanding of SDH after infused in curriculum (simulations, clinical evaluation)?
- How do you infuse SDH throughout the curriculum especially when you don't have control over individual faculty courses? (Faculty development, commitment by faculty to infuse into individual courses and curriculum review of full curriculum to identify how each course is addressing)

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- Development of and commitment to inter-professional activities that highlight acquisition of SDH data from patients at different levels, how the information can be used to support the patient and improve health outcomes.
- Integrate requirements for infusing SDH throughout curriculum.
- Resource development for addressing student individual level SDH.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Vulnerable Populations

Title of IGNITE Presentation Topic:

Why Rural Matters

Why This Is an Important Topic to Address (brief description):

Access to health care in rural communities has been a unifying cause

Rural family medicine is a touchstone for all of family medicine

Long term relationships, continuity of time and place, the direct impact on community outside of clinic, and the wide breadth of clinical skills make family medicine the most important discipline in Rural America.

What We Think We Know (Bulleted evidence + Seminal references):

72 percent of US land mass is rural
20 percent (50 million) of the US population lives in rural communities
Only 8 percent of physicians practice in rural areas

Access:
Geographic barriers, distance to care

Quality:
Should there be different quality standards in rural?
Rural patients 'know what they signed up for'

What is rural?
US Census definition – anything that is not urban (<2,500)
Office of Management and Budget – non-metropolitan counties (core area <50,000)
HRSA's Office of Rural Health Policy – combines these definitions and RUCA codes (a measure of commuting time and distance, developed by the University of Washington)
https://www.hrsa.gov/ruralhealth/aboutus/definition.html

Questions for Group Discussion

Questions to Address in Group Discussion:

Why should you care about rural?

What about specialty care in rural areas? Don't they need specialists too?

Why is the opioid epidemic worse in rural America?

The divide in US politics is also a rural-urban divide. Should it be?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

Rural medicine is the great unifier

Advocating and encouraging training (RTTs) in rural communities helps us all

GME policy needs to support rural training
(show GME slots per population by state)

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Vulnerable Populations

Title of IGNITE Presentation Topic:

People with Disabilities (Developmental and Intellectual Disabilities)

Why This Is an Important Topic to Address (brief description):

People who have developmental and intellectual disabilities (DD/ID) are a unique and medically distinct population who have both the right and natural inclination to live in typical settings in the community. While they may have financial access to medical resources through government payers, that access is limited by physical, linguistic, cultural, and administrative barriers and the content of care received is adversely impacted by deficits in attitudes, skills, and knowledge among health care professionals. Most people with ID/DD rely on others for assistance with daily activities, so the quality, configuration, and funding of the broader service system is a critical element of health and wellbeing. People with DD/ID rank high in poverty, unemployment, social isolation, and other health determinants. Race and ethnicity amplify some disparities. People with DD/ID constitute 2% of the US population, but many of the factors that affect their health are generalizable to the health status of people who have acquired disabilities caused by the effects of chronic illness, injury, aging, and other factors, which represents 19% of the US population. This population also experiences significant disparities.

What We Think We Know (Bulleted evidence + Seminal references):

~ Average age of death for people with DD/ID: women =62.5 (general population = 81.1), Men =59.9 (general population=76.3). This is multifactorial.
~ Sepsis, pneumonia, and dementia deaths are 50-100% higher than the general population
~ Women with ID/DD are 2-3 times less likely to have regular Pap smears and mammograms than women without disabilities or who have acquired disabilities
~ 45.1% of people with DD/ID reported no physical activity in the month they were surveyed and 31.6% indicated inadequate social support compared to 10% and 7.1% in the “no disability” population
~ African American adults with DD/ID are less likely than white individuals with DD/ID to have physical exams, dental care, and influenza vaccine
- Family income is a more powerful predictor of these disparities than race and ethnicity

-Havercamp SM, Scott HM. National health surveillance of adults with disabilities, adults with intellectual and developmental disabilities, and adults with no disabilities. Disabil Health J. 2015 Apr;8(2):165-72.
-AAMDMD, Health Disparities Consensus Statement, https://aadmd.org/articles/health-disparities-consensus-statement
-V. Bradley; Exploring Health Disparities Among People with Intellectual and Developmental Disabilities. What Are the Issues and Do Race and Ethnicity Play a Role?, http://www.nationalcoreindicators.org/upload/presentation/FINAL_NASDDDS_2014_Health_Disparities.pdf

Questions for Group Discussion

Questions to Address in Group Discussion:

~ What does it mean to have a disability? Is this a medical condition, social construct, or something else? Are people with disabilities a "special" population?
~ How can people with DD/ID, their families, direct care workers, and advocates be more actively included in efforts to reduce disparities in preventive services, medical outcomes, and social determinants of health?
~ What are the implications of the findings that race, ethnicity and income intensify health disparities for people with DD/ID and how can this be addressed?
~ How can health care professionals and administrative staff improve their ability to provide medical care for people with DD/ID and better organize systems of care to meet their needs?
~ What are the "right" indicators of health outcomes for people with DD/ID? How can research be better structured? How can complex issues of informed consent be successfully navigated?
~ The population of people who have disabilities of all types is increasing and it is known that they experience significant disparities in health status. How can these disparities be addressed and what are the implications of this for the configuration of the health care system in the future? What lessons can be learned from the experience of people with DD/ID?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

~ People with DD/ID should be formally recognized as constituting a "medically underserved population" by the HRSA and other federal agencies, and receive the consideration, benefits, opportunities and assistance provided to populations with that designation.
~ Curricula for health professions students and resources for practicing clinicians should include education and point of care information about medically specific issues related to DD/ID to improve care.
~ Methodologies for quality improvement should be applied to reduce disparate causes of mortality and to improving access to preventive services for people with DD/ID.
~ Research should be focused on the development of more evidence-based clinical guidelines and the dissemination of best practices to enhance health promotion, disease prevention, and specific treatment for people with ID/DD.
~ Health systems, public health resources, and individual clinicians in conjunction with payers should have accountability for the outcomes of care for people with DD/ID, including quality of life measures. This is particularly significant as major changes in Medicare, Medicaid, and public funding of disability-related resources at the federal, state, and local level are contemplated.
~ Family members and direct care workers, who have essential roles in the daily lives of people with DD/ID, should be valued for the work they do and supported to be effective health partners.
~ People with DD/ID, their families, direct care workers, and advocates must be integrally involved in all elements of efforts to reduce disparities and reshape the care system to better serve their needs.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Vulnerable Populations

Title of IGNITE Presentation Topic:

Racism, Sexism and Unconscious Bias

Why This Is an Important Topic to Address (brief description):

For many decades it has been consistently shown that African-Americans have shorter life expectancies than any other racial/ethnic group in the United States. While other racial/ethnic groups have disparities in health outcomes when compared to non-Hispanic whites, the outcomes of other groups are not as consistently bad as that of blacks. For over three decades, significant efforts have been made to decrease and ultimately eliminate health disparities by race/ethnicity. While some progress has been made, African Americans are still more likely to die from heart disease, breast, cervical, prostate, and colon cancers, stroke, diabetes, homicide, HIV/AIDS and infant mortality when compared to their non-Hispanic white counterparts. Hispanics are more likely to die from cervical cancer, diabetes, homicide and HIV/AIDS when compared to whites. While the causes of health and healthcare disparities are multifactorial, it is increasingly clear that racism and unconscious bias are significant contributors to poor outcomes. It is also clear that sexism has contributed to a delay in understanding differences in disease prevalence, presentation, course, treatment and outcomes when comparing women to men. The role of sexism in contributing to increased rates of chronic pain, depression and anxiety in women is poorly defined.

What We Think We Know (Bulleted evidence + Seminal references):

- In 1985, the Report of the Secretary's Task Force on Black and Minority Health documented six main causes of excess mortality; cancer, cirrhosis, diabetes, heart disease and stroke, homicide and accidents, and infant mortality. Soon after the report was issued HIV/AIDS was added to this list.
- In the three decades since the report was issued a multitude of studies have documented persistent disparities in health and healthcare outcomes between non-Hispanic whites and blacks in particular.
- In 2003, the Institute of Medicine Report entitled Unequal Treatment: Confronting Racial and Ethnic Disparities identified racism and discrimination as contributors to disparity.
- Unconscious bias is increasingly being recognized as a contributor to health care disparities.
- The role of sexism as a contributor to health disparities has not been clearly identified.

- *Health, United States 2015 with Special Feature on Racial and Ethnic Health Disparities NCHS*
- *Smedley BD, Stith AD, Nelson AR. Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care. Washington D.C.: National Academy Press; 2002.*
- *Andrulis DP, Siddiqui NJ, Purtle JP et al. Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations. Joint Center for Political and Economic Studies. 2010.*
- *Chapman EN, Kaatz A,Carnes M. Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities. JGIM 2013;28(11):1504-1510*

Questions for Group Discussion

Questions to Address in Group Discussion:

1. Can health disparities by race/ethnicity be eliminated in the face of a widening income and wealth gap in the United States?
2. How can we better understand the specific contributions of poverty, low literacy, racism and unconscious bias to persistent health disparities by race/ethnicity?
3. Does the recognition of unconscious bias result in less bias or conscious bias?
4. Do Hispanic blacks suffer similar levels of disparity in outcomes as non-Hispanic blacks? Is it important to answer this question?
5. Could epigenetics play a role in increased susceptibility to disease and poorer outcomes in African Americans?
6. Does sexism contribute to worsened health outcomes in women in general? In women of color in particular?
7. What new challenges to the quest to eliminate health disparities are presented by the current administration?
8. How do we more effectively partner with communities to eliminate health disparities?
9. How do we more effectively address racism, sexism and unconscious bias in academic health centers and in society as a whole?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

1. There is a need to develop effective methods of educating health professions and social science students, faculty and staff about the adverse effects of implicit bias on the health outcomes of a variety of patient categories including those who are: racial/ethnic minorities, poor, LGBT, obese, women, intellectually challenged, and from minority religious groups.
2. More research should be done examining the adverse effects of poverty on health outcomes regardless of race.
3. Research should be conducted to measure disparities in health outcomes in Hispanic patients by race.
4. Policies and laws against discrimination based on race/ethnicity, gender, religion, and sexual orientation need to be strengthened and enforced.
5. The impact of the mass incarceration of black men on black families and communities needs to be further examined.
6. All communities should be encouraged to engage in anti-racist, anti-sexist, anti-homophobic organizing.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Vulnerable Populations

Title of IGNITE Presentation Topic:

Immigrant Populations in a Nation of Changing Policy

Why This Is an Important Topic to Address (brief description):

The health of both documented and undocumented immigrants has become a topic of public health concern in recent years, and a growing body of research attempts to understand the impact of immigration policy on the well-being of immigrant communities. While the US economy relies on undocumented immigrants for filling the labor needs in a number of occupations, these individuals remain excluded from many public benefits, rights, and resources that could promote their health and the health of their families. Within a federal policy environment that is often exclusionary, states have increasingly played a role in shaping the social and economic factors that affect the health of undocumented immigrants. The topic of immigrant health is especially important to discuss now after the signing of the recent executive orders by President Trump.

What We Think We Know (Bulleted evidence + Seminal references):

Immigrants in the US today (13.5% of US population; 27% of US population when including immigrants & their US-born children; 3.5% of US population that are undocumented) References: 2015 American Community Survey(ACS); 2016 Current Population Survey; 2010-14 ACS Survey

How state policy impacts immigrants

- Inclusive policies: expanding social inclusion beyond federal policy
- Exclusive policies: further restricting benefits, rights, and resources

How states rank in 5 areas that affect health of undocumented (public health and welfare benefits; higher education; labor and employment practices; driver licensing and identification; and the federal enforcement program, Secure Communities)
Reference: Rodriguez, Wallace, Young; *Creating Conditions to Support Healthy People: State Policies that Affect the Health of Undocumented Immigrants and their Families*, 2015

Federal Policy Impact: Benefits and Challenges for the ACA on Community Health Centers serving immigrant populations
Reference: Wallace, Young, Rodríguez, Bonilla, Pourat; *Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the ACA Era*, 2016

Impact of 3 Executive Orders on Immigrants (2017)

- Enhancing Public Safety in the Interior of the United States (EO 13768)
- Border Security and Immigration Enforcement Improvements (EO 13767)

– Protecting the Nation from Foreign Terrorist Entry into the United States (EO13769)

Questions for Group Discussion

Questions to Address in Group Discussion:

- How can policy action and enforcement at both the state and local level have an influence on the ultimate impact on the health and well-being of undocumented immigrants?
- What are the barriers to immigrant health policy reform and how can they be addressed?
- What effective methods can be put into place to address and challenge the present day policy landscape that will affect immigrant populations?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

State/Local level Policy Areas:

1. Expand laws that actively grant undocumented immigrants' with rights beyond federal standard (such as driver's licenses, access to high education, and access to health care)
2. Buffer impact of federal laws that restrict undocumented immigrants' rights or access to resources via state and local involvement in enforcement, such as limited the use of E-Verify, or limiting cooperation with the Priority Enforcement Program
3. Strengthen laws that are not explicitly immigration-related, but that create a legal or social environment that is more inclusive and beneficial to undocumented immigrants, such as strong labor and employment protections and higher education affordability
4. Explicitly include undocumented immigrants in policies that apply broadly to the population, but in which legal status limits the level or type of benefits available, such as through the SNAP funding formula and workers' compensation statutes.

Federal and Other Policies:

1. Wider variety of social welfare policies that provide basic rights
2. Policies specific to health issues and labor issues
3. Admin and implementation support and policies at the state and local levels that promote immigrant integration (such as ESL classes, legal assistance in seeking deferred action or other options for obtaining lawful status, and professional licenses w/out regard to immigration status
4. Policies that create a climate of acceptance of all immigrants

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Vulnerable Populations

Title of IGNITE Presentation Topic:

Intersectionality – The Interconnectedness of Class, Race, Gender, and Other Types of Vulnerability

Why This Is an Important Topic to Address (brief description):

Studies of disparities in health and health care typically report on differences across a single dimension of social advantage/disadvantage (e.g., racial majority vs. minority). In reality, however, all people live on multiple axes of advantage/disadvantage, including gender, class, sexual orientation, and disability status, among others. Intersectionality is an approach that considers multiple sources of inequality collectively, rather than in isolation, as determinants that shape the degree of advantage or disadvantage experienced by a given person, community, or population. By considering multiple axes simultaneously, intersectional approaches may provide more refined and accurate determinations of which people or groups are most vulnerable. This in turn might lead to more effectively targeted policies and programs to reduce inequities. There are, however, theoretical and practical challenges to implementing intersectional approaches.

What We Think We Know (Bulleted evidence + Seminal references):

- Many studies have shown health and health care disparities by sociodemographic characteristics (e.g., race/ethnicity, gender, social class, rural vs. urban), but few studies have examined “micro”-groups at the intersection of multiple axes of social advantage/disadvantage (e.g., disabled, rural-dwelling, immigrant Latina women).
- Groups with multiple vulnerabilities are in most need of resources or programs aimed at reducing health inequities.
- Intersectional approaches offer more nuanced and useful data on health equity.
- Taken to its extreme, however, intersectionality takes an “anti-categorical” stance that views each individual as occupying a unique social position with a complex array of characteristics, making it difficult to study population-level health disparities. Most studies of intersectionality have accordingly used qualitative rather than quantitative methods.

- *Green MA, Evans CR, Subramanian SV. Can intersectionality theory enrich population health research? Soc Sci Med. 2017 Apr; 178:214-216.*
- *Bowleg L. The problem with the phrase women and minorities: intersectionality-an important theoretical framework for public health. Am J Public Health. 2012 Jul;102(7):1267-73.*
- *Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: A*

Canadian perspective. Crit Public Health. 2008 Sept;18, (3): 271–283.
- *Caiola C, Docherty SL, Relf M, Barroso J. Using an intersectional approach to study the impact of social determinants of health for African American mothers living with HIV. ANS Adv. Nurs. Sci. 2014 Oct-Dec;37(4):287-98.*

Questions for Group Discussion

Questions to Address in Group Discussion:

- Is it feasible to measure all potential axes of advantage/disadvantage?
- Which should be considered most important?
- If several axes are included simultaneously, how do we deal with the problem of small "cells" when generating data?
- What are the practical considerations in deciding whether to use or not use an intersectional approach to measuring and monitoring health equity?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- Intersectional approaches to conceptualizing health equity have several potential benefits:
  - By explicitly considering different forms of vulnerability, it avoids conflating them (e.g., race and SES).
  - It also avoids highlighting some forms of vulnerability and not others (e.g., race but not SES), thereby reducing the potential for backlash by groups (or advocates for those groups) whose vulnerability is not being explicitly acknowledged.
  - It allows for the identification of the most vulnerable subgroups within larger heterogeneous categories.
- Implementation of intersectional approaches to measuring and monitoring health equity poses several potential challenges:
  - Some forms of vulnerability are difficult to measure or capture in available public health and health system data.
  - Quantitative analysis of data using an intersectional framework will require sophisticated statistical methods and likely large datasets.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Economics & Policy

Title of IGNITE Presentation Topic:

International Efforts to Reduce Health Disparities

Why This Is an Important Topic to Address (brief description):

In 2011, Professor Barbara Starfield wrote, *"Inequity is built into health systems- especially western health systems that are based on a view of health needs disease by disease. Therefore, the benefits of primary care, which is person- and population-, rather than disease-focused, are underappreciated. Data provide evidence not only of its (primary care's) benefit to populations but also of its preferential benefit to the socially disadvantaged."*

There is a clear link between poverty and poor health. Uneven distribution of social determinants of health affect health outcomes such as life expectancies and risk behaviours. The way health systems operate in different countries systematically affects the affordability to healthcare services and access of populations to good health.

Moreover, health inequities are not simply dichotomously distributed among the rich and the poor, but also occur within socioeconomic classes. And there is an indissoluble link between health equity and social justice, and our success as health professionals in making a difference for our patients, that relies on all of us working together to advocate for greater socioeconomic equity and the improved health outcomes that will follow.

The work of Professor Starfield provides guidance for physicians and policy makers who seek to improve the health of all people, particularly populations who suffer the consequences of social deprivation. In 2007 Professor Starfield linked family medicine directly to global health and equity. In contrast to the global health contributions of specialty disciplines, such as infectious diseases and pediatrics, Professor Starfield proposed a unique role for family medicine in strengthening health systems based on the demonstrated link between family medicine-centered health systems and greater equity, better outcomes, and improved cost-efficiency. This remains relevant today as the global health community acknowledges the need to balance disease-focused and subpopulation-focused approaches with efforts to create health systems that are more accessible, more responsive, more resilient, and ultimately more equitable for all.

What We Think We Know (Bulleted evidence + Seminal references):

A wealth of evidence by Professor Starfield and her colleagues has shown repeatedly that the strength of a country's primary health care system has been found to significantly improve determinants of population health.

Thanks to the work of Professor Starfield and others, the importance of strengthening primary health care, as a way of addressing health inequities in nations across the world, has been gaining global momentum, especially since the publication of the 2008 World Health Report, Primary Health Care Now More Than Ever.

This has been further reinforced with the 2015 launch of the Sustainable Development Goals, and the focus of SDG 3 on Universal Health Coverage. Universal Health Coverage will not be achieved without strong primary health care in each nation.

Examples of nations which have achieved impressive progress in addressing health inequities through investment in strong community-focussed models of primary health care delivery include not only Western nations like The Netherlands, Denmark and the United Kingdom, but also nations like Brazil, Cuba and Iran.

Seminal references include:

- World Health Organization**. Primary health care: now more than ever**. 2008.
- World Health Organization. **Closing the gap in a generation: Health equity through action on the social determinants of health.** 2011.
- Starfield B, Shi L, Macinko J. **Contribution of primary care to health systems and health.** *Milbank Quarterly*, 2005; 83: 457-502.
- Starfield B. **Global Health, Equity, and Primary Care.** *Journal of the American Board of Family Medicine,* 2007; 20 (6:) 511-513.
- Macinko, J, Starfield B, & Shi L, **The Contribution of Primary Care Systems to health Outcomes within Organization for Economic Cooperation and Development (OECD Countries, 1979-1998),** *Health Services Research*, 2003; 38: 3.
- Macinko J, Guanais FC, de Fátima M, de Souza M. **Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990-2002**. *Journal of Epidemiology and Community Health*, 2006; 60 (1): 13-19.

Questions for Group Discussion

Questions to Address in Group Discussion:

- Recognizing that the benefits of primary care, including health equity improvements, are amplified when care is higher quality, what can we do to improve performance measurement and the quality of primary care systems globally?
- What are the lessons from countries which have been most successful in addressing health inequities through improvements in primary health care?
- What are the factors that we can each most influence to lead to improvements in health equity?
- How do we improve the equitable distribution of health resources according to health needs?
- How do we encourage countries to invest in strengthening their primary care workforce?
- How do we train our current and future health workforce to better recognize and address health inequities, and to be advocates for change?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- Need for continuing research into performance measurements and the factors that impact on the quality of primary care systems globally
- Need for improvements in the education of all members of the health workforce on health inequities
- Need for strengthened investment in each nation in primary health care, including ensuring investment in the primary care workforce

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Economics & Policy

Title of IGNITE Presentation Topic:

ACA Opened the Door for Payment Reform and Practice Transformation to Address SDoH, Now What?

Why This Is an Important Topic to Address (brief description):

Payment and practice transformation have been encouraged by the Affordable Care Act (ACA) under the rubric of value-based pay or value-based care. In Oregon, the Oregon Primary Care Association (OPCA), Federally Qualified Health Centers (FQHCs), and the state Medicaid program changed Medicaid payment for FQHCs and Rural Health Clinics (RHCs) in 2013 to minimize emphasis on the billable visit and shift the clinics' focus to team-based care that includes addressing SDoH interventions. Additionally, Oregon's Coordinated Care Organizations (CCOs) have been using a flexible services program to target some Medicaid managed care payments toward SDoH interventions. These efforts are starting to shift health care dollars to services that are more meaningful to vulnerable populations' health than traditional medical services.

Simply put, the FQHC Alternative Payment Methodology (APM) converts payments to a PMPM rate. Capitation is not new, but the amount of payment that these pilot clinics are receiving free from the visit opens up a lot of opportunity to innovate. When you combine the FQHC APM Medicaid payments and other revenue FQHCs receive that are free from the visit or FFS form of payment (e.g., the 330 grant to serve uninsured patients and 340B pharmacy revenue), most of the clinics are receiving over 80% of their revenue from payment that is disconnected from FFS. These primary care clinics are collecting SDoH information on their populations through empathic inquiry, segmenting populations by SDoH barriers and medical condition, and testing SDoH interventions. They are also partnering with CCOs, social service agencies and public health to address patient and population health issues. Critical to sustaining these efforts, the clinics are developing a value equation for payers and funders to support the work as the health care system transitions to value-based pay. How will this work evolve under the new federal administration?

What We Think We Know (Bulleted evidence + Seminal references):

- SDoH have a much larger impact on health than our health care system
- The PCMH model can be a better way of delivering primary care to improve health outcomes and decrease cost
- Other countries spend more on social services, less on health care and have better health outcomes
- The current fee-for-service system for primary care is structurally flawed.

McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. Health affairs, 21(2), 78-93. http://content.healthaffairs.org/content/21/2/78.full

https://www.ncqa.org/Portals/0/Programs/Recognition/NCQA%20PCMH%20Evidence%20Report,%20June%202015.pdf

Squires, D., & Anderson, C. (2015). US health care from a global perspective: spending, use of services, prices, and health in 13 countries. Issue brief (Commonwealth Fund), 15, 1-

15. http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

Allan H. Goroll, M.D., N Engl J Med 2008; 359:2087-2090, November 13, 2008, DOI: 10.1056/NEJMp0805765. Reforming Physician Payment

Questions for Group Discussion

Questions to Address in Group Discussion:

How have health care payers in your community started recognizing and paying for SDoH interventions and who is delivering these services?

What efforts do you know of that are creating an ROI for SDoH interventions that can be used with health care insurance companies?

How do you think value-based pay for health care should evolve to take SDoH barriers and interventions into account?

Should there be an adjustment to health outcome targets and/or health care payments for psychological and socio-economic barriers? Why or why not?

What strategies should primary care clinics that serve vulnerable populations employ to be successful in value-based pay?

Will the opportunity for paying for SDoH interventions for Medicaid and Medicare patients increase, decrease or remain the same under the new federal administration?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

An ROI needs to be developed for health care payers to invest in SDoH interventions.

Risk adjustments for psychological and socio-economic barriers should be developed for health care patients.

There needs to be a common methodology developed for capturing SDoH barriers to improve patient care and payment that supports better care.

State and federal policymakers should consider investments in social services as part of their strategy to improve health outcomes and lower the total cost of health care.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Economics & Policy

Title of IGNITE Presentation Topic:

Community Vital Signs: Achieving Equity through Primary Care Means Checking More than Blood Pressure

Why This Is an Important Topic to Address (brief description):

A milieu of social, environmental occupational and economic factors collectively labelled the social determinants of health (SDH) have a greater combined influence on the morbidity and mortality of our patients than the services we deliver in traditional medical care. And yet, we as health care providers rarely have the training or tools necessary to identify and address social determinants in the patients, panels, and populations we serve. In an age where health information and geospatial technology, publically available small area data on the social determinants, patient portals and acceptance of individual SDH data collection, it is time for providers and care teams to complement the richness of biometric data immediately available to them in patient and population health care with "community vital signs". (Community VS) would provide an aggregated overview of the social and environmental factors impacting patient health. Knowing Community VS could inform clinical recommendations for individual patients, facilitate referrals to community services, and expand understanding of factors impacting treatment adherence and health outcomes. This information could also help care teams target disease prevention initiatives and other health improvement efforts for clinic panels and populations. Given the proliferation of big data, geospatial technologies, and democratization of data, the time has come to integrate such Community VS into the electronic health record (EHR) and the processes of primary care.

What We Think We Know (Bulleted evidence + Seminal references):

- Place matters to personal and population health, and primary care sits at a critical juncture between the public health, health care, and community resources[1]
- The National Academy of Medicine and National Quality Forum both recommended inclusion of SDH in Electronic Health Records, and identified actionable SDH domains for inclusion in EHRs [2][3]
- Pathways to Integrating SDH into data systems but also Primary Care delivery pathways are being investigated and implemented[4]
- Primary data collection from patients are being tested
- Publically available small area data can be combined with clinical data to achieve patient and

[1] Westfall JM. Cold-spotting: linking primary care and public health to create communities of solution. J Am Board Fam Med 2013;26:239–40

[2] Institute of Medicine. Capturing social and behavioral domains in electronic health records: phase 1. Washington, DC: The National Academies Press; 2014.

[3] National Quality Forum. Multi-stakeholder input on a national priority: improving population health by working with communities – Action guide 1.0. Washington, DC: National Quality Forum; 2014.

[4] DeVoe JE, Bazemore AW, Cottrell EK, et al. Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice. *Ann Fam Med*. 2016;14(2):104-108. doi:10.1370/afm.1903.

panel level 'community vital signs'[56]
- It is critical that we invest in implementation science and training pathways to promote their further inclusion and to advance primary care's role in achieving health equity

Questions for Group Discussion

Questions to Address in Group Discussion:

- Which SDH data are most feasible and meaningful to capture?
- And what are the best points of capture for (e.g. via patient portals, waiting room kiosks, provider-patient interaction, secondary or administrative data linkages)?
- What data should be collected from patients? Vs captured and appended to records administratively? And what are the limitations and strengths of each (veracity, relevance, administrative burden, etc)?
- How do we build the evidence base and implementation science knowledge to effectively address SDH via Primary Care?
- What are the implications for the training pipeline in primary care? For community engagement strategies?
- How should this impact alternative payment models and reimbursements to primary care for the health of their populations?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- Practice: Current information systems mostly lack tools for SDH data capture and use, and providers already stressed by increasing administrative and financial burdens of transformation may balk at the additional training, time, and finances implicit in 'addressing SDH' absent shifts in payment incentives, moves towards true team-based care and richer community partnership opportunities.
- Education: Current medical and graduate medical education lacks the science base, best practices and curricula required to create competency in emerging primary care graduates in effectively addressing SDH
- Research: There is a desperate need to build the evidence base and implementation science knowledge to effectively address SDH via Primary Care

[5] Bazemore AW, Cottrell EK, Gold R, Hughes LS, Phillips RL, Angier H, Burdick TE, Carrozza MA, DeVoe JE. *"Community Vital Signs": Incorporating geocoded social determinants into electronic records to promote patient and population health.* J Am Med Inform Assoc. 2015 Jul 13. pii: ocv088. doi: 10.1093/jamia/ocv088.

[6] Hughes LS, Phillips RL, DeVoe JE, Bazemore AW. Community Vital Signs: Taking the Pulse of the Community While Caring for Patients. The Journal of the American Board of Family Medicine. 2016;29(3):419-422.

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STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Economics & Policy

Title of IGNITE Presentation Topic:

How Social and Environmental Determinants of Health Can Be Used to Pay Differently for Health Care

Why This Is an Important Topic to Address (brief description):

The 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act required the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to review the evidence linking social risk factors with performance under existing federal payment systems — and to suggest strategies to remedy any deficits they found. ASPE commission the National Academies of Sciences, Engineering, and Medicine to convene an ad hoc committee to identify social risk factors that affect health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. The Committee on Accounting for Socioeconomic Status in Medicare Payment Programs has produced 5 brief consensus reports and ASPE released a concluding report in December of 2016. Despite pointing to a lack of sufficient data, the signal is increasing that payment may be adjusted for social determinants. The UK and New Zealand both have decades of experience with ecologic data adjusting payments for healthcare and social services. The PRIME Registry will soon have the capacity to provide social determinant data and to facilitate practices' case for payment adjustment.

What We Think We Know (Bulleted evidence + Seminal references):

Ecologic data are sufficiently tied to outcomes that they are a good starting place
New Zealand and the UK have demonstrated improvements associated with weighted payments
The National Quality Forum believes that quality measures should also be weighted
Community Vital Signs can also be constructed at the patient level to identify patients in greatest need of social services
PHAsT aims to help practices enter this fray

1. Phillips RL, Liaw W, Crampton P, et al. How Other Countries Use Deprivation Indices—And Why the United States Desperately Needs One. Health Affairs. 2016;35(11):1991-1998.
2. Butler DC, Petterson S, Phillips RL, Bazemore AW. Measures of Social Deprivation That Predict Health Care Access and Need within a Rational Area of Primary Care Service Delivery. Health Services Research. 2012;48(2pt1):539-559.
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4. Fiscella K, Burstin HR, Nerenz DR. Quality measures and sociodemographic risk factors: To adjust or not to adjust. JAMA. 2014;312(24):2615-2616.
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Questions for Group Discussion

Questions to Address in Group Discussion:

Are ecologic data sufficient for payment adjustment?
What data should be collected from patients?
How (much) should payments be adjusted?
What should practices do with enhanced payments?
How do we prepare or support practices in partnering with communities?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

Practice: Direction for more resources to practices caring for underserved communities, potential to help practices understand patient risks and avoid penalties for poor quality that is related to patient circumstances

Community Action: Helps make practices a community agent of information and for partnership to solve social determinant-related problems

Research: Much needed to do it right, to study effects, to guide interventions, and to evaluate outcomes

STARFIELD SUMMIT

...where primary care research inspires policy and practice

STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Access to Primary Care is not Enough: A Health Equity Road Map

Title of IGNITE Presentation Topic:

Access to Primary Care is not Enough: A Health Equity Road Map

Why This Is an Important Topic to Address (brief description):

- The POWER study provided actionable data for policy makers, providers, and consumers in their efforts to improve health and reduce health inequities in Ontario.
- The POWER Study approach integrates clinical, public, and population health measures, emphasizing indicators that are modifiable and that can support efforts to link measurement to intervention and improvement. (www.powerstudy,ca)
- The POWER Study identified many large and modifiable inequities in health and health care that are cause for concern despite universal access to primary care.
- Lower-income Ontarians had worse health and functional status, had more chronic disease risk factors, received less preventive care, and had worse health outcomes than those with higher incomes.
- Coordinating across population health, public health, and health system efforts will help accelerate progress towards achieving health equity.

What We Think We Know (Bulleted evidence + Seminal references):

- The impact of health inequities is large. If all Ontarians had the same health as Ontarians with higher income, an estimated 318,000 fewer people would be in fair or poor health, an estimated 231,000 fewer people would be disabled, and there would be an estimated 3,373 fewer deaths each year among Ontarians living in metropolitan areas.
- We estimate that 30 percent of hospitalizations for four common ambulatory care sensitive conditions (ACSCs) (heart failure, chronic obstructive pulmonary disease, diabetes, and asthma)— or almost 16,000 hospitalizations a year—could potentially be avoided if the hospitalization rates observed among adults living in the highest-income neighborhoods could be achieved across all neighborhood income levels.
- These sizable inequities were identified within a system of universal healthcare where over 90% of the population has a primary care provider.
- These findings illustrate the enormous opportunities to improve overall population health while reducing health inequities.
- First, inequities in health and functional status were much larger than inequities in access to and quality of care. This finding underscores the importance of moving upstream to address the root causes of health inequities, which are grounded in the social determinants of health.
- Second, inequities in access to primary care and chronic disease management were

larger than inequities in treatment of acute conditions, highlighting the need to focus on primary care and community services.
- Third, the observed gender differences highlight the need for gender-sensitive solutions.
- Fourth, where there was an organized strategy for quality improvement in place informed by performance measurement, few inequities were observed.
- The POWER Study developed a leading set of health equity indicators and a health equity road map to inform efforts to eliminate disparites.
  - Bierman AS, Shack AR, Johns A, for the POWER Study. Achieving Health Equity in Ontario: Opportunities for Intervention and Improvement. In: Bierman AS, editor. Project for an Ontario Women's Health Evidence-Based Report: Volume 2: Toronto; 2012.
  - Starfeld B, Shi L, Macinko J. *Contribution of primary care to health systems and health. Milbank* Q 2005;83(3):457-502.

Questions for Group Discussion

Questions to Address in Group Discussion:

- How can the Health Equity Road Map be applied to other settings to help develop a comprehensive strategy for eliminating disparities in health and health care?
- How can we engage communities in identifying Health Equity Indicators that can be used to help guide and evaluate interventions and monitor progress toward achieving the important goal of health equity?
- Can this approach to examining gender, socioeconomic, race/ethnic, and regional differences in access, quality, and outcomes of care be applied to other contexts and environments?
- How can coordination between population health, public health, and health system efforts be improved to accelerate progress?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

The study reveals a number of areas for improvement:

- Targeting the Social Determinants of Health
- Chronic Disease Prevention and Management
- Patient-Centered Care
- Integration and Care Coordination
- Innovation, Learning, and Research

Additionally, the study had demonstrated that health equity needs to be monitored more effectively. In particular, measurement capacity can be enhanced through data development in the following areas:

- Gender Relevant Measures
- Data on Ethnicity and Language
- Prescription Drug Data
- Primary Care Data
- Enriched Clinical Data
- Patient-Reported Outcomes
- Dataset Linkage